

RECEIVED

District Health Officer No. 2,

District File Number 839-166

Date Filed 8-30

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Leo H. Hedges

Licensed Embalmer No.

3803

P. O. Address

New Madrid, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30387
Do not use this space.

1. PLACE OF DEATH
(a) County Scott Registration District No. 821
(b) Township Richland Primary Registration District No. 6070
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Lloyd Willard Crister
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
23 6 1
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED 1-23 1940 Wm Crister Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 24 1939
22. I HEREBY CERTIFY That I attended deceased from to 19.....
I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:
Date of onset
Other contributory causes of importance:
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) John P. Dugan M.D.
(Address) Charleston Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Exact statement of OCCUPATION is very important. so that it may be properly classified.

S-30354